

**UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS**

Dean Langford and Nancy Langford,
husband and wife,

Plaintiffs,

v.

Zimmer, Inc. and Zimmer Holdings, Inc.,

Defendants.

Case No: 03-12245-RCL

EXHIBIT D TO AFFIDAVIT OF JAMES S. REECE

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ST. LUKE'S HOSPITAL
OPERATIVE REPORT

Langford, Dean T.,
MR #918953

DATE OF OPERATION: 03/27/2001

SURGEONS: M. P. BRODERSEN, M.D.
G. P. DUFFY, M.D.

ASSISTANTS: M. O. ABUEG/T
D. M. HEATH, PA-C

PRE-OP DIAGNOSIS: PATHOLOGIC FRACTURE LEFT FEMUR SECONDARY TO FAILED LEFT TOTAL HIP ARTHROPLASTY.

POST-OP DIAGNOSIS: Pathologic fracture left femur secondary to failed left total hip arthroplasty.

OPERATION: Revision left total hip arthroplasty.

PROCEDURE:

The patient was anesthetized supine and then transferred into the right lateral decubitus position where the left hip and thigh area were prepped and draped in the usual manner. I opened his old incision and this had a peculiar angle to its distally. We ended up extending that incision distally and curving it back along the lateral side of the leg. We carried the incision down to the skin and subcutaneous tissues. The fascia was incised in a straight manner longitudinally at about the level of the skin incision. We then exposed the posterior aspect of the hip joint removing the external rotators and posterior capsule from the posterior aspect of the greater trochanter and performed a posterior capsulectomy. A medial and anterior capsulotomy were performed. The stem was grossly loose and we dislocated the hip easily and then dissected releasing the vastus lateralis from the lateral aspect of the femur along the linea aspera distally. We identified the fracture site and exposed that. There was significant bone destruction in this area. There was a large area laterally where the bone had completely disintegrated as well as another even larger area anteriorly that was approximately 10 cm long. The amount of bone destruction was markedly worse than could be appreciated on the x-rays. We exposed the distal end of the fracture and could push the femoral component back and the femoral component was easily removed. We then worked on removing the cement both proximally as well as distally. This required meticulous care because of the quality of the bone. We did not unfortunately sustain any fractures of the bone in removing the cement. We then reamed distally and found that we could ream the 16.5 mm and at that level, the bone was tight. We then came back and reamed proximally and had to use a burr to open up the canal both distally and proximally because of some bone overgrowth.

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Next, we cleaned the acetabular component circumferentially. We used an osteotome to remove the all polyethylene. This was a 28 mm internal diameter socket size H. A new Zimmer liner was then inserted. The posterior thickened flange was at about the 2 o'clock position. The metal shell was tested prior to inserting the new socket liner and was stable. We then inserted a real DePuy fully coated AML 10 inch Solution stem. We were careful with our version as we wanted to obtain a good press fit in the distal portion of the fracture. This was accomplished very nicely. I left the prosthesis just a little bit proud. This was done intentionally so as to try and restore his leg length. An 8.5 mm neck length 28 mm width head was then applied to the trunion and excellent stability was obtained. We then re-approximated the bone ends of the fracture and then applied two strut grafts, tibia strut graft anteriorly and a femoral strut graft laterally. The holes in the bone were packed with allograft bone graft mixed with Grafton putty. The bone graft was then applied over that and then we used Luque wires to fix the bone graft in place. An excellent construct was obtained with good stability. I was very happy with that. Again, I could move the leg through a good range of motion without causing any disruption in our construct. Gentle irrigation was accomplished and then the wounds were repaired using #0 Vicryl to repair the vastus lateralis to the linea aspera. #1 Ethibond was used to repair the gluteus maximus to its base through drill holes in the bone as well as to repair the external rotators and posterior capsule to the posterior aspect of the greater trochanter again through drill holes in the bone. #1 Vicryl was used to repair the fascia. #2-0 Vicryl was used in the subcutaneous tissues and staples were used to repair the skin. Sterile dressings were applied. The patient was then carefully transferred back to his bed and an abduction pillow was applied. He tolerated the surgery well and transferred to the recovery area in satisfactory condition. All sponge and needle counts were correct. It should be noted that we did send tissue at the beginning of the case to pathology for frozen section and there was no evidence of acute inflammation. This tissue was from the hip socket area.

Dr. Duffy, A. Vickars, PA-C, D. Heath, PA-C and M. Abueg, ST assisted throughout the procedure.

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TYPE I - CLEAN

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M. P. Broder

M. P. BRODERSEN, M.D.

G. P. Duffy

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